Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 1-29-01.
   b. The request was received on 1-29-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 5-29-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 5-31-02. The response from the insurance carrier was received in the Division on 6-6-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 1-29-03:
   "Please be informed that the procedure code of 64712 has the MAR allowance of $850.00 per TWCC, (confirmation enclosed), and that is exactly what we submitted; yet they paid $818.00. So, this confirms that we are within the allowed fee schedule. And as for the code of 25085, the charge submitted was $546.00, and this was reduced by $273.00, per the multiple procedure rule. According to the Multiple Procedure rule, D, 1, C, 'Secondary or subsequent procedures performed in remote areas that are unrelated to the primary procedure and requiring additional preparation shall be reimbursed at the lesser of the provider's usual and customary fee or 100% of the MAR.' This patient had **two** procedures performed, to **two separate sites through two separate incisions,** which

required additional preparation for each site. The operative report is enclosed and will confirm this situation. Therefore, these two procedures are primary procedures performed to **two separate sites** and require full payment as stated in the above ruling."

2. Respondent: Letter dated 6-6-02:
"Provider seeks additional reimbursement of $32 for CPT code 64721. Reimbursement for CPT code 64721 was reduced by $32 for a previously allowed office visit which is included in the follow-up for the surgery as explained on the EOB as follows: 'An office visit was previously billed, which is included in the follow-up of the surgery. The amount of the previously billed visit and any overcharge from the surgery procedure has been disallowed with this line.' Provider's Statement of Position provides no response to the reason given for reduction…Provider seeks additional reimbursement of $273 for CPT code 25085. The MAR for this procedure was reduced by 50% pursuant to the Commission's Multiple Procedure Rule. Under that rule, Provider is only entitled to 100% of the MAR for the secondary procedure *if* the secondary or subsequent procedures are 'performed in remote areas that are unrelated to the primary procedure and requiring additional preparation.' In this case, the secondary or subsequent procedure was not performed in a remote area and was not unrelated to the primary procedure. It was performed on the same wrist and was also related to the primary procedure, the carpal tunnel release. Therefore, the MAR for CPT code 25085 was properly reduced by 50%."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 1-29-01.

2. The carrier denied the billed services as reflected on the EOB as, "UBY – AN OFFICE VISIT WAS PREVIOUSLY BILLED, WHICH IS INCLUDED IN THE FOLLOW-UP OF THE SURGERY. THE AMOUNT OF THE PREVIOUSLY BILLED VISIT AND ANY OVERCHARGE FROM THE SURGERY PROCEDURE HAS BEEN DISALLOWED WITH THIS LINE"; "UNL – THIS MULTIPLE PROCEDURE WAS REDUCED 50% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES"; "ZFK – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE;" "ZGT – (F) 002 THE CHARGE EXCEEDS THE SCHEDULED ALLOWANCE FOR MULTIPLE PROCEDURES."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
1-29-01	64721	$850.00	$818.00	UBY,ZFK	$850.00	MFG: Surgery Ground Rules; CPT Descriptor	The carrier has inappropriately reduced the code billed. The carrier has indicated the reduction was for a previously paid office visit that should have been included in the FUD. This can be addressed in a Dispute Resolution process, request for refund. Therefore additional reimbursement is recommended in the amount of **$32.00**.
1-29-01	25085	$546.00	$273.00	UNL, ZFK	$546.00	MFG: Surgery Ground Rules (I) (D) (1) (c); CPT Descriptor	Review of the preoperative diagnosis were carpal tunnel syndrome and an occult volar ganglion cyst which involved the volar capsule and cystic area in the volar distal scaphoid. Review of the operative report indicates that CPT Code 25085 was performed through a separate transverse incision to the wrist wherein the dorsal capsulectomy was carried out. MRI indicated a cystic structure at the base of the capitate. A cyst was also shown in the dorsal ulnar aspect of the lunate. This procedure is considered a separate procedure and unrelated to the primary procedure. Therefore, additional reimbursement is recommended in the amount of **$273.00**.
Totals		$1,700.00	$1,394.50				The Requestor **is** entitled to reimbursement in the amount of **$305.50.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$305.50** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 4th day of February 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll